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Insert:

- Update to the Payment Schedule

PROVINCIAL EMERGENCY SERVICES PROJECT

The Provincial Emergency Services Group is developing standards for patient care as part of its mandate to improve the utilization, effectiveness and access of the emergency system in B.C. The Provincial Emergency Services Project (PESP) has introduced a protocol initiative that will provide the tools for emergency departments to incorporate the latest clinical guidelines into day-to-day patient care management in an effective, coordinated and efficient way. This is in recognition of the fact that emergency department protocols are being published at an increasing rate but that there is not a coordinated approach by which these protocols can be screened, reviewed and adopted into practice.

The Emergency Department Protocol Working Group (EDPWG), under the direction of PESP, has developed tool kits and processes for the implementation of an asthma management protocol based on accepted best practice in the industry. The EDPWG is chaired by an Emergency Room Physician and has health authority representation from medical, clinical management, quality improvement and clinical education. In addition, experts in each protocol subject area are consulted throughout the process.

The tool kit and implementation processes for the asthma management protocol have been tested in six pilot sites and are currently being rolled out across the province. The work done at the pilot sites has confirmed that there are significant benefits in adopting a consistent approach to protocol implementation, including:

- Improved consistency of clinical practice;
- Means for examining current practice and closing gaps in care;
- Physician and staff time is saved by using standard guidelines;
- Realignment of existing resources to improve efficiency and patient flow;
- Access to up-to-date information on new developments in the field e.g. care for pediatric asthma cases;
- Improved follow-up care by providing linkages to community-based clinics;
- Standard tools for staff training and in-services;
- Process for streamlining quality improvement activities; and
- Opportunity for a systematic approach to protocol maintenance.

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BRITISH COLUMBIA Ministry of Health

BONE DENSITY MEASUREMENT – Update

Since the Payment of Bone Mineral Densitometry (BMD) article in the Summer 2005 issue of this newsletter, we have received questions asking for clarification on payment for repeat bone mineral densitometry scans. We were also asked whether coverage of BMD testing is provided for women taking Depo Provera.

The Bone Density Working Group of the Guidelines & Protocols Advisory Committee reviewed the literature relating to the potential need for bone mineral density testing in patients treated with depo-medroxyprogesterone acetate (Depo Provera) for the purposes of hormonal contraception. The working group endorses the position of the World Health Organization* (WHO) until more evidence is available. The WHO position states that any change in bone density is small and largely reversible in individuals receiving Depo Provera. Since osteoporotic fractures are extremely uncommon in premenopausal women, and any lifetime increase in fracture risk is likely to be small as a result of the use of Depo Provera, there is currently no evidence to support a benefit from BMD testing in these individuals.

To clarify questions on repeat bone mineral density testing, an excerpt from the Guideline, *Bone Density Measurement in Women, Revised 2005* follows. The complete guideline and patient guide is available on the MSP web site at:
http://www.health.gov.bc.ca/msp/protoguides/gps/bone_density.pdf

or call 250 952-1347 or fax 250 952-1417 to request a copy.

Follow-up bone density measurements are not considered necessary prior to two years after the original measurement except:

- in patients receiving ≥ 7.5 mg prednisone daily or its equivalent for three months consecutively who require a baseline examination and repeat scans at six-month intervals while on treatment;
- in patients with existing fractures or with very low bone density in whom an earlier examination may be indicated.

The response to many of the drugs used to treat osteoporosis is characterized more by a reduction in fracture incidence than by an increase in bone density. Follow-up measurements of bone density should be interpreted with this fact in mind.

Note: Please refer to the notes subsequent to the BMD listings in the MSC Payment Schedule for information about repeat bone mineral density testing for males.

**World Health Organization and UNDP, UNFPA, WHO World Bank Special Programme of Research, Development and Research Training in Human Reproduction. WHO statement on hormonal contraception and bone health. July 2005.*

Available at: http://www.who.int/reproductive-health/family_planning/docs/hormonal_contraception_bone_health.pdf

INFORMATION FOR NEW PATIENTS IN BC

MSP is requesting your assistance to ensure new residents apply for MSP coverage upon arrival in BC. When you are seeing a new patient who has recently moved to the province, please advise them to apply for MSP coverage immediately.

It has come to our attention that some new residents believe that they cannot make application for benefits until they have completed their wait period and this is not the case.

New residents or persons re-establishing residence in B.C. are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months.

For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

A new resident should apply for MSP coverage immediately upon arrival in B.C. This will ensure their application can be processed in time for benefits to start on their date of eligibility.

BILLING FOR MULTIPLE FAMILY MEMBERS DURING THE SAME VISIT

There are many legitimate reasons for more than one person in a family to attend a physician's office for medical care at the same time. In cases where each family member seen receives medical diagnosis and/or treatment, it is appropriate to bill for each service. However, when only one family member has a medical problem, it is almost always inappropriate to bill for discussion with other family members about the patient's condition.

For example, if a parent and child are both seen for diagnosis and treatment of upper respiratory infection during the same visit, a visit fee may be billed for each patient. However if the child is seen for upper respiratory infection and the physician takes the history from the parent and gives treatment instructions to the parent, a visit fee may only be billed for the child. Standard medical care of a patient may require that the physician communicate with a parent, spouse, or caregiver of the patient. Such routine communication is considered to be included in the one visit fee paid for medical services to the patient, even if such communication is rendered on a different day. Please refer to Preamble, Section B.1-7.

Individual counselling is the only exception when a claim can be made in the name of a person other than the patient when the counselling is regarding that patient. As stated in the Preamble to the Medical Services Commission (MSC) Payment Schedule, "Counselling is not to be claimed for advice that is a normal component of any visit, or as a substitute for the usual patient examination fee, whether or not the visit is prolonged". In other words, time is a necessary requirement, but time is not sufficient in itself to justify billing a counselling fee. The Preamble also states: "Not only must the condition be recognized as difficult by the medical profession, but the physician's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. Unless the patient is having significant difficulty coping, the counselling listing normally would not be applicable to the subsequent visits in the treatment of this disease". These statements make it very clear that billing a family member of the patient for advice regarding the patient is to be an exception not the rule. Please refer to Preamble, Section B.4.

Group counselling fees are not appropriate for advice relating to a single patient. These fees only apply when all members of the group are receiving medically required treatment or medical psychotherapy (i.e. each member of the group is a patient).

This information is provided to highlight some of the sections of the MSC Payment Schedule that deal with seeing more than one family member during the same visit, and is not expected to replace a thorough reading of the Preamble itself.

Note: this article was originally published in the Winter 1999 Physician Newsletter but the information is still applicable.

BLUEBOOK AVAILABLE ON MSP WEB SITE
http://www.health.gov.bc.ca/msp/

The 2004/2005 Medical Services Commission Financial Statement (Bluebook) can be accessed on the MSP Web site at http://www.health.gov.bc.ca/msp/. It is listed under "Publications" on the menu bar. The Statement contains an alphabetical listing of payments made to practitioners, groups, clinics, hospitals and diagnostic facilities for the past fiscal year.

Should you wish to purchase the financial statement from Crown Publications, you can order a copy by telephone 250 386-4636, fax 250 386-0221 or mail:

521 Fort Street
Victoria, British Columbia
V8W 1E7

For more information visit the Web site at: http://www.crownpub.bc.ca.

BILLING INTEGRITY PROGRAM

Purpose of the Billing Integrity Program

The Billing Integrity Program (BIP) provides audit services to the Medical Services Plan (MSP) and the Medical Services Commission (MSC). The MSC is authorized and obligated to monitor the billing and payment of claims in order to manage expenditures for medical and health care on behalf of MSP beneficiaries. Audit of practitioner billings is a recognized utilization management and cost-saving activity that is supported by the British Columbia Medical Association (BCMA) and respective health care associations for chiropractic, physical therapy, massage therapy, podiatry, dentistry, naturopathy and optometry.

Acting in the public interest and in the interest of most practitioners who bill MSP appropriately, BIP monitors and investigates billing patterns and practices of medical and health care practitioners to detect and deter inappropriate and incorrect billing of MSP claims. In cooperation with the professions, BIP develops and applies monitoring, case finding and audit criteria.

If you would like more information regarding the monitoring and investigation of billing patterns of practitioners or you wish to register a complaint, contact BIP at:

Telephone: 250 952-2829
Email: hlth.bip@gov.bc.ca
Web site: http://www.health.gov.bc.ca/msp/infoprac/bip.html

Supervision of Delegated Procedures

Billing for procedures delegated to employees of a physician, other than services performed in a 'diagnostic facility', is governed by MSC Payment Schedule Preamble B.5 Delegated Procedures. In particular, diagnostic procedures delegated to physicians' employees must be directly supervised by a suitably qualified physician who is physically present in the clinic or office. Examples of diagnostic services requiring a physically present physician include:

- Allergy, patch and photopatch tests 00762, 00763, 00764,00765, 00767, 00768, 00769
- Diagnostic skin tests 00030
- Diagnostic urological procedures 000802,00792, 00878, 00874, 00875, 00876
- Graded exercise test 00336 etc (cardiology listing), 01730 etc (rehabilitation medicine listing)
- Laboratory procedures short list (laboratory listings page 31-45).
- Ophthalmology laboratory/diagnostic examinations 02027, 02032 and 02037
- Peak expiratory flow 00930
- Diagnostic ultrasound (notwithstanding being a designated diagnostic facility service)

The above limitations do not apply to designated diagnostic procedures, when performed in approved "diagnostic facilities", as defined in the Medicare Protection Act, and which are subject to the Diagnostic Accreditation Program.

Audit Reports

Dr. A - General Practice/Emergency Medicine

A general practitioner engaged in full time emergency medicine practice was audited by the Medical Services Commission (MSC) because of unusually high cost-per-patient stemming directly from a high rate of Level II and III Emergency Care billings. Upon reviewing the medical records, the medical inspector found that some visits lacked the required documentation to support the level of care billed.

As the result of a negotiated settlement, the physician agreed to repay the MSC $28,000, inclusive of costs and interest, and comply with a pattern of practice order in which the physician would maintain adequate medical records and would comply with the Emergency Medicine Preamble in respect to criteria for levels of complexity of care.

Dr. B – General Practice and Dr. C – General Practice

Two physicians practicing in the same rural community came to the attention of the Billing Integrity Program when it was observed that the cost-per-patient was significantly higher than the provincial average, even after adjustment for patient age, gender and morbidity. An on-site audit of both practices was ordered by the Audit and Inspection Committee (AIC) of the MSC, and performed by a practicing peer medical inspector. The clinical records were legible and complete, and resulted in a finding of no material billing errors. The AIC, upon reviewing the findings, ordered both cases closed and thanked the physicians for their co-operation with the audit process.

Dr. D - Pediatrics

A pediatrician was audited by the MSC due to a complaint and a service verification survey. Some referring physicians indicated that they had either not referred patients for consultation or that they had not received a written consultation report following a referral. The on-site audit by a peer medical inspector examined both office and intensive care unit services but, despite the results of the verification letter survey, found excellent clinical records and only minor billing errors with no systematic pattern of irregularities. Through an alternative dispute resolution process, the parties reached a mutually agreed upon solution whereby the practitioner agreed to reimburse the Medical Services Plan (MSP) for only admitted errors and the MSC closed the file.

Billing Tips - Pediatric Consultations and Same-Day Neonatal Intensive Care Unit (NICU) Admission

Some pediatricians and neonatologists have been observed billing both a consultation and same day critical care for the same patient. In most cases, the physician has attended a difficult birth and then admitted the patient to the neonatal intensive care unit or special care nursery. According to the MSP Payment Schedule NICU listing (page 5-8), the consultation is included in the critical care fee and is therefore not separately billable.

Physicians who provide adult and pediatric critical care and bill the 1400-series fee items are reminded that they are subject to a similar provision on page 5-2 of the preamble to the Adult and Pediatric Critical care listings.

As always, billing audit tips are educational in nature, and are not exhaustive. Refer to the MSC Payment Schedule and regulations for a complete understanding of requirements and conditions.

Group Counselling - Reminder

Physicians are reminded that group counselling fee items (00121, 00122, 00313, 00315, 01713, 01715) are payable once 'per group', not once 'per patient' in the group. When submitting the group counselling claim, the physician must include the names of all patients in the electronic note record. However, in the event of an onsite audit, the physician would be required to identify all participants and provide an adequate medical record on each individual patient. Therefore physicians who bill group counselling are advised to include the PHN # of all participants in the electronic note record field, maintain an office appointment book listing all participants and an adequate medical record for each.

Since counselling is a time-based service, it would also be prudent for the physician to record the start and stop time in the medical record, in order to substantiate the duration of the service.

Group counselling must represent medically necessary face-to-face discussion with two or more patients, and be personally rendered by the physician. Consequently, group counselling may not be billed for case conferences, chart rounds or other discussions with medical or allied health care staff.

As always, billing audit tips are educational in nature, and are not exhaustive. Readers should refer to the MSC Payment Schedule and regulations for a complete understanding of requirements and conditions.

New Diagnostic Facility Assignment Form

A new fill and print PDF Diagnostic Facility Assignment Form is now available online at

https://www.health.gov.bc.ca/exforms/mspprac/index.html#assignmentdiagnostic

Clarification of Fee Item 01215

Anesthetic surcharge (01215) is only applicable for cases that commence prior to 1800 hours and when the following conditions are met:

- Anesthetic service is provided on an emergency basis
- Anesthetic service is associated with an elective surgery that because of intervening emergency surgery commences prior to 1800 hours but extends beyond 1800 hours

When emergency services (or services associated with an elective surgery bumped by an emergency surgery) commence prior to 1800 hours on a weekday and extend beyond 1800 hours, anesthetic surcharges are applicable only to the time after 1800 hours. Timing begins at 1800 hours and surcharge payments are based on one half hour of care or major portion thereof. In this case the 01215 would be payable after 15 minutes of continuous care (i.e. 1815 hours).

Billing Tips for Fee Item 01215

- When claims are submitted for fee item 01215 the start time entered in the time field on the claim must be 1800 hours or later (between 1800 and 2300 hours) even if the anesthetic service commenced prior to that time. If the start time indicated on the claim for fee item 01215 is prior to 1800 hours the claim will be refused with explanatory code CF.

- When emergency services commence prior to 1800 hours "CCFPP – continuing care from a previous patient" is not required in the note record, for that case, however the duration of time must be at least 15 minutes for one service.

- The anesthetic IC levels should continue to be billed as one claim for the total anesthetic time to avoid unnecessary delays in payment.

Replacement of Fee Item G14000 by G14004 and G14009

Effective December 31, 2005 fee item G14000 will expire and will be replaced by two new fee items. This fee item change was implemented to facilitate physician billings and to assist with any billing problems created by fee item G14000.

New Fee items with slightly revised wording and note added to indicate only one premium payable per day.

G14004 Incentive for full service general practitioner – obstetric delivery bonus associated with vagir al delivery and post natal care $258.33

Notes:

i) Payable to family physician performing the first delivery of the day.
ii) Physician must also be responsible (or share responsibility) for providing patient's general family practice medical care.
iii) Payable only when fee item 14104 billed in conjunction.
iv) Maximum of one bonus per patient delivered, up to a maximum of 25 bonuses per calendar year.
v) Only one obstetrical bonus payable per day, under either FI 14004 or 14009.

G14009 Incentive for full service general practitioner – obstetric delivery bonus related to attendance at delivery and post-natal care associated with emergency caesarean section $215.17

Notes:

i) Payable to family physician performing the first delivery of the day.
ii) Physician must also be responsible (or share responsibility) for providing patient's general family practice medical care.
iii) Payable only when fee item 14109 billed in conjunction
iv) Maximum of one bonus per patient delivered, up to a maximum of 25 bonuses per calendar year.
v) Only one obstetrical bonus payable per day, under either FI 14004 or 14009.

Clarification: The 25 bonus limit per year is applicable to any combination of the two new fees (i.e. not 25 of each, but 25 in total)

New Explanatory Codes

New explanatory codes have been developed to replace explanatory code NP and to help physician offices identify the reason a claim was debited.

The new explanatory codes are:

NQ The incentive for full service GP obstetrical delivery bonus is payable for the first delivery the GP attends on the date billed.

NR The incentive for full service GP obstetrical delivery bonus is payable to a maximum of 25 bonuses per calendar year.

Update - Chronic Incentive Payment Fee Item 13050

This update is to clarify the use of the 13050 chronic incentive payment for the care of patients with diabetes or congestive heart failure. The original information is available on the Ministry web site under the Full Service Family Practice Program at: http://www.health.gov.bc.ca/cdm/practitioners/fullservice.html

The 13050 is a management bonus, intended to compensate for the time taken to maintain patient care plans in accordance with the BC clinical guidelines. Please note that the application of guidelines for patient care requires professional judgment. The Guidelines recognize variations in patient need, and payment is not dependent on every recommendation being followed for every patient and is not dependent on all recommendations or targets being achieved.

Balancing Mastopexy

Mastopexy is a benefit of the Medical Services Plan only when performed following breast cancer surgery. The fee items for balancing mastopexy are:

P61166
Mastopexy, balancing unilateral (isolatedprocedure)
$313.79 Anaes. Level 3

P61167
Mastopexy, balancing - when performed at same time as contralateral breast surgery
$255.34 Anaes. Level 3

IMPORTANT DATES

2006 Close-Off Dates

Jan 4, 2006	Jul 5, 2006
Jan 20, 2006	Jul 20, 2006
Feb 6, 2006	Aug 3, 2006
Feb 17, 2006	Aug 22, 2006
Mar 6, 2006	Sepr 6, 2006
Mar 22, 2006	Sep 20, 2006
Apr 4, 2006	Oct 3, 2006
Apr 19, 2006	Oct 20,2006
May 4, 2006	Nov 3, 2006
May 19, 2006	Nov 21, 2006
Jun 6, 2006	Dec 6, 2006
Jun 21, 2006	Dec 18, 2006

Designated Statutory Holidays – Year 2006

January 2, 2006	Monday	in lieu of New Year's Day
April 14, 2006	Friday	Good Friday
April 17, 2006	Monday	Easter Monday
May 22, 2006	Monday	Victoria Day
July 3, 2006	Monday	in lieu of Canada Day
August 7, 2006	Monday	BC Day
September 4, 2006	Monday	Labour Day
October 9, 2006	Monday	Thanksgiving Day
November 13, 2006	Monday	in lieu of Remembrance Day
December 25, 2006	Monday	Christmas Day
December 26, 2006	Tuesday	Boxing Day

TELEPLAN WEB TIPS: SECURITY – November 2005

A secure connection with the Medical Services Plan is assured using Internet Standards such as Secure Sockets Layer (SSL) technology. Each session uses encrytpted information to provide authentication – look for the "padlock" icon at the bottom of the panel. Your session is also secured by administrative controls applied to your datacentre and by maintaining the access to the User ID (UserName) supplied by the Teleplan Support Centre.

Follow the guidelines below to ensure that your User ID and Password are unique and cannot be used or accessed by anyone else:

Your Teleplan4 Web password must:

1. contain a minimum of six characters or more
2. contain a mix of characters from these categories:
   - english upper case characters (A to Z)
   - english lower case characters (a to z)
   - numerical digits (0 to 9)
3. not contain any part of your username used to log in
4. not contain month and year only
5. avoid passwords that contain full words (e.g. 'firetruck') or words found in a dictionary
6. avoid street names, address, birth date, family, pets including guessable attributes if someone knows the person
7. avoid repetition of characters or patterns (e.g., 123x123y; xyxy12)
8. change your password regularly before it expires as your password issued by us will expire in 42 days.

The system does not allow you to reuse the same password and a warning will be issued when it is time to change your password.

Note:

1. We recommend you change your password a few days before payment close-off to avoid last minute problems.
2. We prefer that you contact the Teleplan Support Centre if you receive a message of invalid password after two attempts, as the system will automatically revoke your password after three attempts.

If you forget your password and need to have it reset please contact the MSP Teleplan Support Centre at: Victoria: 250 952-2668 or rest of BC: 1 800 663-7206

REGISTERED NURSE PRACTITIONERS BEGIN PRACTICE

British Columbia's first group of nurse practitioners (NPs) graduated from the University of British Columbia in May 2005 with Masters Degrees. Nurse practitioners are registered nurses with advanced education and skills who can diagnose illnesses, order investigations and prescribe medications.Three B.C. universities, UBC, UVic and UNBC each have 30 spaces available for NP students over a two year program. By the end of 2006, there will be an estimated 40 NPs registered to practice in British Columbia.

The province's new regulation governing registered nurses took effect on August 19, 2005 and allows NPs to perform reserved actions with full autonomy within their scope of practice. In order to practice, they must meet the requirements set by the College of Registered Nurses of British Columbia (CRNBC). These requirements include passing a written examination and successfully completing the Objective Structured Clinical Examination.

Initially, government identified primary health care, geriatric care and mental health as priority areas of practice for NPs in British Columbia. Subsequently, the first group of nurse practitioners to graduate from UBC and UVic this year are all family NPs. However, as health authorities have assessed their needs and posted jobs, it has become clear that NPs are also needed in acute care settings such as cardiology, orthopedics and renal dialysis. According to Dr. Ian Blue, nursing program chair at UNBC, "The role of a family nurse practitioner is to provide high quality health care at whatever level and in whatever circumstance they are required, and that's going to vary enormously from region to region."

Today, six NPs are fully registered and working in British Columbia. Additional graduates have completed their examinations and will become registered in January 2006. These NPs are accepting positions now.

The introduction of NPs in B.C. is the result of more than three years of implementation planning and consultation. Since 2002 the Ministry of Health has consulted with stakeholder groups including the BC Medical Association and the College of Physicians and Surgeons on policy issues and guiding principles related to regulation of the NP role.

Commenting on public acceptance of nurse practitioners as members of interdisciplinary health care teams, Dr Blue observed, "nurses view the delivery of care differently from physicians. That's not a comparison between who is better and who is worse, but medical care is delivered in a different way than nursing care and nurse practitioners will deliver nursing care. They do it with a nursing perspective and I think that's why the public surveys say they like them and they feel they've cared for them successfully."

It was agreed in discussions with the Medical Services Commission that diagnostic services and initial consultations provided by physicians on a valid referral from a registered nurse practitioner would be funded outside of the Available Amount. Physicians submitting claims for payment for referrals and diagnostic work should indicate the practitioner number of the nurse practitioner in the "referred by" field.

A full list of diagnostic tests and referrals NPs may make can be found on the CRNBC website at: http://www.crnbc.ca/downloads/424.pdf

NEW EXPLANATORY CODES

IG	Fee is not applicable unless the physician is called from another site to render the emergency service. Resubmit with details of where you were called from.
MS	Does not meet the criteria for billed services for hospitalized patients.
MT	Sub Acute Care has been paid during the period you have billed for Acute/Supportive care. Please verify the location of the patient.
MV	Acute/Supportive Care has been paid during the period you have billed for Sub Acute Care. Please verify the location of the patient.
QL	Assists and visits are not paid together unless distinct unrelated times are provided.

COVERAGE ENQUIRIES

There are a number of options available to check patient coverage:

Use the Practitioner Information Line

This automated service handles coverage enquiries using an interactive voice response (IVR) system. The patient's personal health number (PHN) must be provided. If the PHN is unknown, fax a request on a coverage research form to 250 405-3592.

The Interactive Voice Response (IVR) service provides coverage information any time of the day or night. This service allows you to:

- Check the date of patient's last eye examination
- Check patient's initials/surname
- Confirm coverage for date of service
- Transfer to Info-by-Fax

  Victoria: 250 383-1226
  Vancouver: 604 669-6667
  Other areas of B.C. (toll-free): 1 800 742-6165

Patient Information

MSP recognizes that obtaining accurate patient information to submit a claim can sometimes be difficult. The following suggestions may be helpful:

Obtain Patient Information prior to a visit

- When your patients call for an appointment ask for their name and PHN exactly as it appears on their CareCard
- Ask your patients to make sure they bring their CareCard with them to the appointment
- Ask your patients if they have made changes to their name or coverage since their last visit

Confirm Patient Information at the time of the visit

Teleplan4 Web Immediate On Line Eligibility function provides coverage information while the patient is at your office. This service allows you to:

- Check coverage for your patient immediately
- Verify coverage for the current date plus the previous six months
- Learn if a patient is restricted to one physician
- Check when your patient had their last eye examination
- Check if subsidy insured service is paid by MSP or patient

Confirm Patient Coverage prior to the visit

Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information is available the next morning. As your requests are processed overnight this allows you to submit your next day's or week's roster of patients.

GAMMA KNIFE STEREOTACTIC RADIOSURGERY

Update to Summer 2005 Physicians' Newsletter

The Physicians' Newsletter, Summer 2005 announced that, effective immediately the use of gamma knife stereotactic radiosurgery for specified indications would be insured. After further consultation with clinical specialists the following information was developed to clarify the circumstances in which gamma knife stereotactic radiosurgery is insured:

- Gamma Knife stereotactic radiosurgery is considered an insured service when pre-authorized by MSP and when undertaken in approved Canadian centres.

Pre -authorization is based on the following guidelines:

- Pre-authorization must be sought by a medical specialist actively involved in the beneficiary's care with expert knowledge in the proposed service and/or specialty that will deliver the out-of-province service.
- For referrals for diagnoses where gamma knife radiosurgery is indicated, including, but not limited to, acoustic neuroma, meningioma, arterio-venous malformations, and brain tumours, authorization will be based on the recommendation of the clinical specialist.
- For referrals for malignant brain tumours, the request for pre-authorization must be accompanied by a written recommendation from the medical director of the radiation oncology division of the BCCA.
- In the case of referral for the treatment of trigeminal neuralgia (tic douloureux), authorization will be granted for patients with severe disability, and only when medical/surgical treatment available in BC has not proven successful and/or is not indicated in the clinical circumstances.
- For information of referring specialists, authorization for treatment of movement disorders will not be granted.

You will note that these recommendations are generally consistent with the announcement in the Summer 2005 Physicians' Newsletter with the following key differences:

- All referrals for gamma knife radiosurgery require pre-authorization.
- Gamma knife radiosurgery for trigeminal neuralgia will be authorized only when medical/surgical treatment available in BC has not been successful, or is not indicated in the specific clinical circumstance.
- Gamma knife radiosurgery for movement disorders will not be authorized.

BC PALLIATIVE CARE BENEFITS PROGRAM

Since February 1, 2001, BC residents who choose to receive palliative care services at home can receive assistance with the cost of palliative care medications, medical supplies and medical equipment from the provincial government.

The program was originally funded and administered by the Ministry of Health's Home and Community Care Division. Payment for the drugs dispensed to eligible patients under the drug plan portion was facilitated by PharmaCare through PharmaNet. Local health authorities administered the portion of the program dealing with medical supplies and equipment.

As of April 1, 2005, the BC Palliative Care Drug Program portion is fully funded and administered by PharmaCare. Local health authorities retain full responsibility for the administration of medical supplies and equipment.

There are no changes to the eligibility criteria for the program or to the medications included in the Palliative Care formulary. The physician determines a patient's medical eligibility for palliative care benefits.

Note: Individuals covered by the Non-Insured Health Benefits (NIHB) Program of Health Canada or Veterans Affairs Canada (VAC) will require coverage

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... *BC Palliative Care continued*

under the program only if a medication is not covered by NIHB or VAC. Members of the Canadian Forces and RCMP receive coverage through their employers and are, therefore, not eligible for this program.

Information for Physicians is available on the PharmaCare Web site at www.health.gov.bc.ca/pharme (from the Contents menu, select Site Map, then click on Downloads Available):

- Physician Guide New!
- Application form
- Patient information sheet

If you prefer pre-printed copies of the application form, please send a request to the Ministry of Health Warehouse by:

- fax to 250-952-4559, or
- e-mail to james.mcgarry@gov.bc.ca.

For information on medications included in the BC Palliative Care Drug Program formulary, please contact Health Insurance BC (HIBC) using either the new HIBC telephone numbers or the existing numbers for the PharmaNet HelpDesk.

For information on additions to the palliative care formulary, please fax or write to:
Administrative Services for the Palliative Care Drug Benefit Program
PharmaCare Pharmaceutical Services
Ministry of Health
1515 Blanshard Street
Victoria BC V8W 3C8
Fax: From Victoria 250-952-2116 or, from elsewhere in the BC, toll-free 1-800-609-4884.

For information on Special Authority coverage for a drug that is not included in the formulary but is needed to alleviate patient discomfort (and for which there is no substitute in the formulary), please submit a Special Authority Request form to the usual Special Authority Program fax number. The form should be clearly marked "For Palliative Care Registrant" to ensure it receives first priority adjudication and should include adequate documentation.

Information for Patients
Patient information about the program is available on the PharmaCare Web site at www.health.gov.bc.ca/pharme, under the General Information/PharmaCare Plans section.

PROVINCIAL EMERGENCY SERVICES PROJECT – Contacts ... *Continued from page 1*

For more information on the Asthma Protocol contact the Health Authority representative in your region:

NHA	Joanne Cozac (North Central)	250 565-2537
	email: joanne.cozac@northernhealth.ca	
	Gail Eliot (North West)	250 627-0539
	email: gail.eliot@northernhealth.ca	
IHA	Angela DeSmit (North East)	250 262-5308
	email: angela.desmit@northernhealth.ca	
	Sue Carpenter	250 851-7383
	email: sue.carpenter@interiorhealth.ca	
FHA	Kathy McIntyre	604 613-5457
	email: kathy.mcintyre@fraserhealth.ca	
VCHA	Stella Tsang	604 806-8222
	email: sstsang@providencehealth.bc.ca	
VIHA	Brenda Shrink	250 755-7691 (ext. 2100)
	email: brenda.uhrynuk@cvihr.bc.ca	

One of the major achievements of this provincial initiative has been the validation of a process for knowledge transfer and protocol implementation that can be applied to other clinical areas. The Asthma Management Protocol has led the way for the development of a second protocol for dealing with Transient Ischemic Attack (TIA)/Stroke.

ADDITIONS TO PHARMACARE'S LIMITED COVERAGE PROGRAM

To access the detailed Special Authority criteria or request forms for the medications discussed below:

1. Visit the PharmaCare Web site at www.health.gov.bc.ca/pharme.
2. Criteria and forms can be accessed from the PharmaCare home page, select *Special Authority Information*, then select *Limited Coverage Drug Program*.

   To access the forms directly, from the PharmaCare home page, select *Forms*.

Adalimumab (Humira®) for Severely Active Rheumatoid Arthritis

Effective July 20, 2005, adalimumab is available for coverage for the treatment of severely active rheumatoid arthritis. This will be available through the PharmaCare Limited Coverage Program, under the Special Authority process, when prescribed by a rheumatologist or internist with a rheumatology specialty.

The updated coverage criteria for adalimumab are identical to the criteria for etanercept (Enbrel®) and infliximab (Remicade®). PharmaCare covers twenty-six 40mg doses of adalimumab per year, provided at monthly intervals.

Please note that adalimumab should not be used in combination with other tumour necrosis factor (TNF) antagonists.

The initial coverage criteria for anti-TNF medications for the treatment of rheumatoid arthritis have been clarified. These minor changes do not affect renewals for patients with existing Special Authorities.

The Functional Assessment Form that must accompany requests for adalimumab, etanercept, and infliximab has also been updated. It now includes a consent for the release of information, which must be signed by the patient.

Pimecrolimus (Elidel®) Cream and Tacrolimus (Protopic®) Ointment for Corticosteroid-Resistant Eczema

Effective October 17, 2005, pimecrolimus (Elidel®) cream and tacrolimus (Protopic®) ointment are available for PharmaCare coverage under the Limited Coverage Program through its Special Authority process.

PharmaCare will consider a request for indefinite coverage:
- for a patient who has eczema, if the medication is prescribed by a dermatologist; and
- patient is refractory to three months of potent topical corticosteroid therapy; or
- patient is intolerant to topical corticosteroid therapy.

To request Special Authority coverage, please use the general Special Authority Request form (HLTH 5328).

Thiazolidinediones (TZDs) for Type II Diabetes

Effective November 7, 2005, the TZD medications pioglitazone (Actos®) and rosiglitazone (Avandia®) are available for PharmaCare coverage for patients with Type II diabetes. Coverage will be under the PharmaCare Limited Coverage Program, through the Special Authority process.

The criteria for coverage is:

1. Failure of, or intolerance to, metformin PLUS
2. Failure of, or intolerance to, glyburide AND

For patients intolerant to glyburide: Failure of, or intolerance to, gliclazide or another sulfonylurea drug.

Initial coverage is for a 26-week supply. First and subsequent renewals are for a period of one year.

Please note that TZDs should not be used in patients who:

... Continued on page 14

- are receiving insulin treatment,
- have a known sensitivity to TZDs,
- have severe hepatic disease,
- suffer from congestive heart failure of New York Heart Association Class II, III or IV, or
- are pregnant.

Please submit all requests by fax or mail using the appropriate TZD-specific request forms (Initial Coverage HLTH 5358 / Renewal HLTH 5359).

For patients already stabilized on TZDs, please fax completed forms for initial coverage (HLTH 5358) and renewal of coverage (HLTH 5359) simultaneously, providing the requested baseline and current statistical data.

Inclusion of Cyclosporine Capsules in the PharmaCare Low Cost Alternative (LCA) Program

Cyclosporine continues to be available for coverage through the PharmaCare Special Authority process. However, because generic cyclosporine 25mg, 50mg and 100mg capsules are now available, effective November 25, 2005, brand name and generic strengths of cyclosporine capsules will also be included in the PharmaCare Low Cost Alternative (LCA) Program.

The LCA Program helps to keep PharmaCare affordable while preserving patient access to medications. Under the program, PharmaCare sets a low cost alternative price for each LCA category. Any product within an LCA category that falls within one per cent of the LCA price is designated as a full benefit. The remaining products are partial benefits.

When a medication is included in the LCA Program, patients can choose to purchase:

- a full benefit low cost alternative, that will be fully recognized and reimbursed according to the rules of their PharmaCare plan; or,
- a partial benefit drug and pay the difference between the drug price and the price of the low cost alternative. For patients who choose a partial benefit and are receiving assistance under Fair PharmaCare, only the value of the low cost alternative counts towards their deductible.

Patients who have met the published PharmaCare Special Authority criteria and who are already stabilized on Neoral® 25mg, 50mg and 100mg capsules prior to November 25, 2005, will not be affected. They will continue to receive full benefit coverage of these products (subject to the usual rules of their PharmaCare plan) under indefinite PharmaCare Special Authorities that will be in effect on November 25, 2005. No action is required by physicians or pharmacists to secure continuing full benefit coverage of Neoral® capsules for these patients.

Prescription claims for those patients who have not received indefinite Special Authority approvals for cyclosporine and claims for all first-time prescriptions for cyclosporine capsules dispensed on or after November 25, 2005, will be reimbursed as follows:

NEW CATEGORY (CHEMICAL NAME)	DIN	MAN	BRAND NAME	LCA STATUS	PRICE
*CYCLOSPORINE CAP 25MG	2247073	RXP	RHOXAL-CYCLOSPORINE CAP 25MG	F	$1.0327
	2150689	NVR	NEORAL CAP 25MG	P	
*CYCLOSPORINE CAP 50MG	2247074	RXP	RHOXAL-CYCLOSPORINE CAP 50MG	F	$2.0135
	2150662	NVR	NEORAL CAP 50MG	P	
*CYCLOSPORINE CAP 100MG	2242821	RXP	RHOXAL-CYCLOSPORINE CAP 100MG	F	$4.3163
	2150670	NVR	NEORAL CAP 100MG	P	

**Cyclosporine is a Limited Coverage Drug requiring Special Authority approval (please visit the PharmaCare Web site at www.health.gov.bc.ca/pharme for the Special Authority criteria).*

MSP BULLETIN WINTER 2006

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal Agreement of Limitation form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07834
9034793801	06/59	F	06468
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

BRITISH COLUMBIA Ministry of Health Services

Update to the Medical Services Commission
Payment Schedule

Preamble

In accordance with Section 26(3) of the *Medicare Protection Act*, the following modifications to the Payment Schedule have been approved by the Medical Services Commission, effective August 19, 2005:

Amendment:

The following paragraphs of the indicated Sections of the Preamble to the Payment Schedule are hereby modified:

B.3 Consultation

a. General

A consultation applies when a physician, or a non-physician practitioner (chiropractor, for orthopaedic consultations; midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a physician competent to give advice in this field. The service includes the initial services of a consultant necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring physician/practitioner. A consultation must not be claimed unless it was specifically requested by the attending physician/practitioner and unless the written report is rendered (refer to Preamble A.15). It is generally agreed that a written report will be generated by the physician providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to a maximum of 90 days is acceptable.

b. Continuing Care by Consultant

Once a consultation has been rendered and the written report submitted to the referring physician/practitioner, this aspect of the care of the patient normally is returned to the referring physician/practitioner. However, if by mutual agreement between the consultant and the referring physician/practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the MSC Payment Schedule pertaining to the pertinent specialty.

Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring physician generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her. For hospitalized patients, supportive care may apply.

Continuing care by a specialist (following consultation) normally is paid at the pertinent specialist rates. However, continuing care requires that a written update of the patient's condition and care be appropriately reported to the primary care physician / practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the Primary Care physician / practitioner.

B.4.e.v) Directive Care/Concurrent Care/Supportive Care (1st paragraph)

Directive care refers to those subsequent hospital visits rendered by a consultant in cases in which the responsibility for the case remains in the hands of the attending physician / practitioner but for which a consultant is requested to give directive care in hospital during the acute phase. Payments for directive care are limited to two visits per patient per week for each consultant requested to render directive care by the referring physician/ practitioner.

Out-of-Office Service Charges

The following notes and fee items are hereby listed in the Out-of-Office Hours Premiums Payment Schedule as indicated:

Explanatory Notes

Add the following paragraph:

l) Physicians providing anesthetic services may be eligible for continuing care surcharges even if the services is initiated before 1800 hours. That portion of anesthetic services rendered within the designated times are eligible for continuing care surcharges if they fulfil the requirements described in the Anesthetic Continuing Care Surcharges section.

The following section is hereby added to Continuing Care Surcharges:

c) Anesthesia

Anesthetic services are eligible for continuing care surcharges when an out-of-office hours call-out charge is applicable or when specially called for an emergency. Timing begins after the first 30 minutes for consultations, visits or anesthetic evaluations. Payment is based on one half hour of care or major portion thereof. Therefore, the first surcharge is payable after 45 minutes of continuous care when a call-out charge is applicable. If a call-out charge is not applicable then the first continuing care surcharge is payable after 15 minutes of continuous care as long as the anesthetic service is rendered within the designated times.

Applicable also, without the 30 minute time lapse and with timing continuing, to immediately subsequent patients seen on the same call-out, under the following conditions:

i) as an emergency;
ii) to provide "top-ups" under fee code 01103 or for obstetrical epidural anesthesia;
iii) to provide subsequent resuscitative care under fee code 01088.

Surcharges do not apply to time spent standing by unless code 01112 is payable and are based on the amount of time providing care, regardless of the number of patients attended or services provided.

P01215	Evening (service rendered between 1800 hrs. and 2300 hrs.) – per half hour or major part thereof	$39.95
P01216	Night (service rendered between 2300 hrs. and 0800 hrs.) - per half hour or major part thereof	$60.14
P01217	Saturday, Sunday or Statutory Holiday (call placed between 0800 hrs. and 1800 hrs.) - per half hour or major part thereof	$43.98

Notes:

*i) State time called **and** time service rendered.*

ii) Where timing is continuous submit an account for each patient, indicating "CCFPP" (continuing care from previous patient).

iii) Not applicable to full or part-time emergency physicians or to on site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.

iv) When emergency services commence prior to 1800 hours (weekday) and extend beyond 1800 hours, anesthetic surcharges are applicable to the time after 1800 hours. Timing begins at 1800 hours and surcharge payments are based on one half hour of care or major potion thereof. Therefore, the 01215 surcharge in these cases is payable after 15 minutes of continuous care (i.e.: 1815 hours)

v) When emergency anesthetic services commence prior to 0800 hours and continue after 0800 hours, anesthetic surcharges are only applicable to the time prior to 0800 hours.

vi) Anesthetic surcharges are applicable to services associated with elective surgery which, because of intervening emergency surgery, extends into or commences within the designated times.

Diagnostic Services

Amendment

The note following the specified listing is hereby modified as indicated:

S00717 Micro-laryngoscopy – procedural fee

Note: 00717 to be charged at 50% if performed with a surgical procedure (not payable in addition to fee items 02423, 02428 or 02429).

Amendment

These items are effective on a temporary basis from June 1, 2005 to November 30, 2007. On November 30, 2007 and after review by the BCMA, a recommendation may be made to remove the temporary status:

T00921 Varicocele and/or uterine artery embolization – unilateral $360.90

T00925 Varicocele and/or uterine artery embolization – bilateral $501.79

Notes:

i) Fee items T00921 and T00925 include all arteriographies necessary to perform the procedure

ii) Fee item 08617 or 08618 payable in addition when service rendered in out-patient department

iii) Interventional Radiology consultation is payable with T00921 and T00925.

The following fee items have been approved on a provisional basis, effective June 1, 2005:

P10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery

$525.00
Anes. Level 2

Notes:

i) Includes any medically necessary angiographies, any necessary imaging, all necessary catheter repositioning and ongoing assessment and care throughout the patient's active treatment phase.

ii) *Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care, up to 36 hours.*

P10902 Peripherally inserted image-guided central venous catheter line (PICC) $100.00 Anes.Level 2

Notes:

i) *Interventional Radiology consultation not payable in addition, regardless of when rendered.*
ii) *Not applicable if performed via other than peripheral access.*
iii) *Includes placement, venogram/angiogram, and all medically required image guidance*
iv) *May not be delegated*

P10903 Percutaneous hemodialysis graft thrombolysis $525.00 Anes. Level 2

Notes:

i) *Includes declotting and treatment of underlying cause of access failure*
ii) *Includes angioplasty and all necessary imaging and intervention*
iii) *Consultation not payable in addition, regardless of when rendered.*

New Fee Items

The following items have been approved on a provisional basis, effective June 1, 2005. This Minute will expire May 31, 2006 or when replaced by a subsequent Minute whichever occurs first:

P10906 Image-guided percutaneous vertebroplasty – first level $325.00
P10907 - each additional level (to a maximum of 3) $75.00

Notes:

i) *Payable only when rendered on in-patient or day-care basis in acute care facility;*
ii) *Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating;*
iii) *Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure;*
iv) *Interventional Radiology consultation not payable in addition.*

P10904 Percutaneous transcatheter arterial chemo-embolization (TACE) $325.00

Notes:

i) *Fee is per session/sitting, regardless of number of lesions treated;*
ii) *Includes all associated imaging necessary to complete procedure;*
iii) *Interventional Radiology consultation is payable.*

P10908 Percutaneous image-guided tumour ablation – first lesion $432.00

Notes:

i) *Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;*
ii) *Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;*
iii) *Includes all CT and ultrasound guidance necessary to complete the procedure;*
iv) *Paid at 50% if repeated within 30 days;*
v) *Interventional Radiology consultation is payable.*

P10909 Percutaneous intravascular/intracorporeal medical device/foreign body removal $350.00

Notes:

i) All angiography, angioplasty and/or intravascular stenting included;

ii) If a second or third medical device /foreign body is removed, payable at 50% each, to a total maximum of three;

iii) Interventional Radiology consultation is not payable.

P10911 Selective salpingography/fallopian tube recanalization (FTR) $350.00

Notes:

i) Hysterosalalpinogram not payable in conjunction with the procedure;

ii) Paid at 2/3 of the fee if unilateral;

iii) FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation;

iv) Any imaging related to the procedure is inclusive.

P10912 Transjugular liver/renal biopsy $350.00

Notes:

i) Ultrasound guidance, venous puncture, central access catheter are included in the fee;

ii) Payable only for uncorrectable coagulopathy;

iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day;

iv) If repeated within 6 months, payable at 50%;

v) Interventional Radiology consultation not payable.

General Practice

The cancellation date of the following provisional items has been extended. This Minute will expire on July 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

P12148 Sub-acute hospital visit $31.31

Notes:

i) Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred from an acute care facility to sub-acute care facility.

ii) Payable 2 times per patient per week. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

iii) Not payable with 00108, 13108, 00128, 13128, 00127, 13127, 13148, 00112, 00109, 00114, 13114, or 00115.

P13148 Sub-acute hospital visit – 1st visit of the day $62.62

Notes:

i) Payable only for first patient seen in a sub-acute facility on any calendar day

ii) Not payable on the same day to the same physician as 13108, 13114, 13127 or 13128 unless provided in a discrete facility which is in a separate geographic location from the acute care or extended care facility.

iii) Not payable on same day to same physician for the same patient in addition to 00108, 00109, 00112, 00128, 13108, 13127, 13128, 12200, 13200, 16200, 17200, 18200 and 13114 except as set out in notes iv) and v).

iv) Essential non-emergent additional visits to a patient in a sub-acute facility by the attending or replacement physician during one day are payable under fee item 12148. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

v) *Fee items 12200, 13200, 16200, 17200, 18200 are payable for addition sub-acute hospital visits same day, same patient when the attending physician or replacement physician is specially called back due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.*

vi) *Sub-acute hospital visits on other than the first visit of the day remain payable under 12148.*

Anesthesia

The following modifications to the Anesthesia listings are effective October 1, 2005. These modifications will be monitored for a period of one year, effective January 1, 2006 to December 31, 2006. After this time they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

Amendment

The description of the following fee item is amended as indicated:

01164	Patients 70 – 79 years of age	$17.74

New fee item

The following new fee item is hereby added to the Anesthetic Procedural Fee Modifiers section of the Anesthesia schedule:

P01165	Patients 80 years of age and over	$24.96

The following new fee item for anesthetic services associated with cataract surgery listings as indicated is hereby added to the Miscellaneous Anesthetic Procedural Fees section of the Anesthesia Schedule:

P01105	Anesthesia for cataract surgery – per 1 minute increment *Note: This item applies to fee code 02188, 02190, 02192, 02196 and 22191.*	$2.00

Dermatology

Clarification

The description of the indicated fee item is modified as follows:

00219	- for each additional lesion – to a maximum of two additional lesions per day

Ophthalmology

The cancellation dates of the following provisional items have been extended. This extension will expire on June 30, 2006 or when replaced by a subsequent Minute, whichever occurs first.

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.:Heidelberg, GDX)	$63.92
P22068	- professional fee	$12.28
P22069	- technical fee	$51.64

Notes:

i) Requires both qualitative and quantitative assessments

ii) Includes examination of both eyes whether at one time or two separate visits

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

The Anesthetic Intensity /Complexity level of the following listings is hereby deleted:

The following modifications to the Anesthesia listings are effective October 1, 2005. These modifications will be monitored for a period of one year, effective January 1, 2006 to December 31, 2006. After this time they will be adjusted retroactively and prospectively to ensure that the actual monetary impact equals the expected impact.

S02188	Cataract – linear extraction, congenital, traumatic or senile
S22191	- capsulotomy (needling or discission), isolated procedure
S02190	Primary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period
S02192	Secondary intraocular lens implantation to include repositioning of lens within the 42-day post-operative period
S02196	Surgical repositioning of implant lens

Internal Medicine

Deleted Fee Items

The following fee items are deleted, effective August 31, 2005:

00321	Master's 2-step electrocardiogram interpretation	$49.72
00339	- technical fee	$32.89
00320	- professional fee	$16.83

Amendment

The note (i) subsequent to fee items 00334, 00335 and 00336 (graded exercise test) is amended as indicated in italics:

Notes:

(i) This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer or pharmaceutical agents, with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained.

Respirology

The following modifications to the Payment Schedule have been approved effective January 1, 2006:

Additions

The following new listings, descriptions and notes are effective as indicated:

The following note is added subsequent to the Sectional heading:

Note: These listings cannot be correctly interpreted without reference to the Preamble.

Referred Cases

32010	Consultation: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report	$137.05
32012	Repeat or limited consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	$65.80
32014	Prolonged visit for counseling (maximum 4 per year) *Note: See Preamble B.4.c.*	$44.80

Continuing Care by a consultant:

32006	Directive care	$38.19
32007	Subsequent office visit	$39.89
32008	Subsequent hospital visit	$23.51
32005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums) *Note: Claim must state time call placed.*	$93.00

Owned Fee Items – Section of Respirology

Ownership of the following fee items is hereby transferred to the Section of Respirology. The current codes, descriptions, notes and fees remain unchanged.

S00700	Bronchoscopy or bronchofibroscopy - procedural fee	$77.71
S00702	Bronchoscopy with biopsy - procedural fee	$124.46
S00736	Bronchial brushing in conjunction with bronchoscopy (bronchoscopy extra) - procedural fee extra	$65.45
S00818	Oesophageal pH study for reflux, extra - professional fee	$40.04
S00817	- technical fee	$12.21
S00910	Overnight home oximetry (continuous recording of oxygen and pulse) - professional fee	$27.36
S00911	Overnight home oximetry (continuous recording of oxygen and pulse) - technical fee	$15.32
S00928	Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	$12.52
S00929	Simple screening spirometry as above but before and after bronchodilators	$18.54

Lung volumes - all subdivision of lung volume, to include vital capacity plus measurement of FRC and residual volume:

S00931	- professional fee	$13.90
S00932	- technical fee	$13.90

Spirometry - forced expiratory spirogram to include FVC, FEV(i) and FEV(i)/FVC ratio, MMEFR, etc.:

S00933	- without bronchodilators - professional fee	$10.90
S00934	- without bronchodilators - technical fee	$10.90
S00935	- before and after bronchodilators - professional fee	$12.52
S00936	- before and after bronchodilators - technical fee	$13.90

Spirometry - flow volume loops:

S00937	- without bronchodilators - professional fee	$10.90
S00938	- without bronchodilators - technical fee	$17.85
S00940	- before and after bronchodilators - professional fee	$13.90
S00941	- before and after bronchodilators - technical fee	$26.40

Diffusion Studies with Carbon Monoxide:

S00942	- at rest or exercise - professional fee	$14.82
S00943	- technical fee	$12.62

Detailed Pulmonary Function Studies:

S00945	- professional fee (includes 00931, 00935 and 00942)	$41.24
S00946	- technical fee (includes 00932, 00936 and 00943)	$39.51

Progressive exercise test with at least three workloads, measuring ventilation and electrocardiographic monitoring:

S00950	- professional fee	$21.67
S00951	- technical fee	$31.97

Ventilation at rest and exercise with blood gas analysis but without expired gas analysis:

S00952	- professional fee	$26.45
S00953	- technical fee	$42.74

Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, and electrocardiographic monitoring:

S00954	- professional fee	$45.09
S00955	- technical fee	$45.09

Exercise in a steady state at two or more work loads with measurements of ventilation, 0_2 and $C0_2$ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space:

S00956	- professional fee	$53.68
S00957	- technical fee	$53.68

Ear Oximetry to measure arterial 0_2 saturation:

S00960	- professional fee	$4.62
S00961	- technical fee	$15.64

Expired gas analysis to measure mixed venous $C0_2$:

S00962	- professional fee	$3.13
S00963	- technical fee	$15.64

Plethysmography and airway resistance:

S00964	- professional fee	$13.21
S00965	- technical fee	$26.40

Lung compliance with pressure volume plot:

S00966	- professional fee	$45.09
S00967	- technical fee	$35.71

Inhalation challenge - assessed by serial flow measurements, per day:

S00968	- professional fee	$35.71
S00969	- technical fee	$35.71

$C0_2/0_2$ responsiveness of respiratory centres by steady state test or rebreathing test:

S00972	- professional fee	$17.85
S00973	- technical fee	$10.90

Inspiratory and expiratory muscle strength

S00974	- professional fee	$12.02
S00975	- technical fee	$12.48

ST11915	Polysomnography, standard – professional fee	$164.17
ST11916	Polysomnography, standard – technical fee	$379.57
ST11919	Multiple Sleep Latency Test (MSLT) - professional fee	$82.09
ST11920	Multiple Sleep Latency Test (MSLT) - technical fee	$189.78

Obstetrics and Gynaecology

Deleted Fee Item:

The following fee item is hereby deleted effective August 31, 2005:

04200	Hysterectomy – subtotal (includes ophorectomy when applicable)	$340.03 Anes. Level 5

Amendment

Effective September 1, 2005, the following item is amended by adding to the indicated note.

04228	Hysterectomy – total	$483.69 Anes. Level 5

Note: Includes salpingectomy/ophorectomy (04003), ovarian cystectomy (04201) and abdominal enterocele repair.

Plastic Surgery

The following modification to the Payment Schedule has been approved effective January 1, 2006.

61057	Nipple areolar reconstruction and tattoing *Notes:* *i) Fee includes initial tattooing whether done at the time of the reconstruction or as a staged procedure, and one additional tattooing* *ii) Subsequent tattooing is not payable by the Plan*	$448.08

The cancellation date of the following provisional items have been extended. This Minute will expire on March 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

PC61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	$746.48 Anes Level 5

Note: The following muscle flaps are payable under this item:
i) biceps femoris flap
ii) deltoid flap
iii) external oblique flap
iv) gastroocnemius flap

v) gluteus maximus flap
vi) gracilis flap
vii) latissimus dorsi flap
viii) pectoralis major flap
ix) rectus abdominus flap
x) rectus femoris flap
xi) soleus flap
xii) trapezius flap
xiii) temporalis flap
xiv) tensor fascia lata flap
xv) triceps flap
xvi) vastus lateralis flap
xvii) vastus medialis flap

PC61157 Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles $560.08
Anes Level 5

Note: The following muscle flaps are payable under this item:
i) brachioradialis flap
ii) coracobrachialis flap
iii) pectoralis minor flap
iv) peroneus brevis flap
v) peroneus longus flap
vi) platysma flap
vii) sartorius flap
viii) serratus flap
ix) sternocleidomastoid flap
x) tibialis anterior flap
xi) tongue flap

PC61156 Mocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles $373.39
Anes Level 5

Note: The following muscle flaps are payable under this item:
i) adductor digiti minimi flap
ii) adductor hallucis flap
iii) adductor pollicis brevis flap
iv) anconeus flap
v) extensor digitorum communis flap
vi) extensor digitorum longus flap
vii) extensor hallucis longus flap
viii) first dorsal interosseous flap
ix) flexor carpi ulnaris flap
x) flexor digitorum brevis flap
xi) flexor digitorum longus flap
xii) flexor hallucis longus flap
xiii) orbicularis oculi flap
xiv) orbicularis oris flap

Radiology

New Fee Item

The following item has been approved on a provisional basis, effective June 1, 2005 – this Minute will expire on May 31, 2006or when replaced by a subsequent Minute, whichever occurs first:

P83000 Interventional Radiology Consultation – to include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of written report $75.00

Notes:

i) Payable only to physicians with appropriate training in interventional radiology

ii) Payable only when rendered in acute care public facilities.

iii) Must be initiated by written request by another physician

iv) Payable only when interventional radiological procedure requires extensive discussion and review of all available data.

v) Includes all patient visits necessary

vi) Payable only when patient is recommended for one of the following interventional therapeutic radiological procedures:

- *a. Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery (10901)*
- *b. Varicocele and/or uterine artery embolization – unilateral/bilateral (00921/00925)*
- *c. Percutaneous image-guided tumor ablation*
- *d. Percutaneous transcatheter arterial chemoembolization (TACE)*

vii) Payable with the following procedures only when the definitive procedure is cancelled subsequent to the consultation:

- *a. Percutaneous nephrostomy (00978)*
- *b. Percutaneous nephrostomy with dilation of tract (00979)*
- *c. Transhepatic biliary drainage procedure (00980)*
- *d. Therapeutic radiological embolization (00981)*
- *e. Percutaneous transluminal angioplasty (00982)*
- *f. Percutaneous abdominal abscess drainage by catheter insertion (00983)*
- *g. Embolization fee codes T00995, T00997, T00998;*
- *h. Abdominal aortic aneurysm repair using endovascular stent graft – radiology component (P10900)*
- *i. Complex diagnostic neuroangiography*

viii) Repeat consultation not applicable for same condition, same patient within 6 months.

Laboratory Medicine

Amendment

The following note is added to the indicated fee item, effective immediately:

92285 Thyroglobulin antibodies

Note: Payable only when performed with 92280

Deleted Fee Items

92295	Thyroid microsomal antibodies	$24.94
92300	Thyroid antibody test	$16.86

New Fee Item

The following item is effective on a temporary basis from July 1, 2005 until December 31, 2007. On December 31, 2007 and after review by the BCMA, a recommendation may be made to remove the temporary status:

T92332	Thyroperoxidase antibodies *Note: Payable only for possible autoimmune thyroid disease*	$19.99

Amendments:

The provisional ("P") status is removed from the following listings:

09826 Tumor Imaging with metabolic or biological imaging agent (excluding thallium – 201 or gallium – 67)
95053 Thallium Body Imaging

The following note is added to the indicated listing:

90645 Chlamydia antigen
Note: Not payable for urogenital specimens.

Amendment:

The following modifications to the payment schedule have been approved by the Medical Services Commission, effective immediately:

1. The description of the following fee item is modified as indicated:

92330 Free T4 $17.46

Notes – Thyroid disease tests:

i) TSH is the preferred test for the initial investigation of thyroid disease and for monitoring thyroid hormone replacement therapy/

ii) For the initial diagnosis of thyroid disease, confirmation of an abnormal TSH with a free T4 is indicated.

iii) Refer to the Laboratory Medicine Preamble and/or Guideline:

iv) "Thyroid Function Tests in the Diagnosis and Monitoring of Adults with Thyroid Disease" for other situations and additional information.

2. The Protocols Section of the Laboratory Medicine Preamble is revised as follows:

PROTOCOLS:

b. **Thyroid Function Test**

i) Physicians are encouraged to order TSH for the initial investigation of thyroid disease and the monitoring of thyroid hormone replacement therapy.

ii) Laboratories should do only one thyroid function test unless additional test(s) are ordered and one of the following conditions exists:

1. the TSH is abnormal
2. the requisition indicates that the patient is a "special case", i.e., on thyroid suppressive therapy or thyroid altering medications: has suspected pituitary or hypothalamic disease or treated hyperthyroidism; or has a history of neck irradiation.
3. the ordering physician added the test(s) after review of the clinical findings and the initial laboratory result(s) or after discussion with a laboratory

physician. (The laboratory should store the specimen for 7 calendar days to enable the physician to request additional testing)

4. the laboratory identifies a medical requirement not specified about (e.g. thyroid cancer treatment).

iii) Laboratories should only perform fT3 in addition to fT4 and TSH if the TSH is abnormal but the fT4 is not elevated and there is suspected hyperthyroidism.

iv) Laboratories may substitute free hormone essays when total T4 or T3 are ordered

v) For further recommendations, refer to the Guideline: Thyroid Function Tests in the Diagnosis and Monitoring of Adults with Thyroid Disease.